North Tampa
Spine & Joint Center
Chiropractic - Physiotherapy - Acupuncture - Massage

Patient Name:_____ Age:_____ Sex:_____ Today's Date:_____

Address: _____ City:_____ State:____ Zip:_____

Are Text Reminders ok?_____ Cell Phone: _____ Date of Birth:_____

Emergency Contact:_____ Contact Number:_____ Relationship:_____

I will be paying today by: __Cash __Check __Credit Card

Email:_____Occupation:_____

Previous Chiropractic Treatment? Y / N Name of Previous Chiropractor:_____

Last Chiropractic Treatment? _____ Primary Care Physician: _____

Referred by *(friend, coworker, physician, family member)?* _____

What type of care are you interested in? ☐ Pain relief only ☐ Healing condition ☐ Optimizing your health

What is your **long term goal** from treatment (ex. play round of golf):_____

Is today's visit due to a work related injury? Yes / No Is today's visit due to an auto accident? Yes / No

(If yes to either question above, check with the receptionist, additional information is needed.)

Date of Injury_____

Patient Signature_____

(Primary Insurance Carrier)_____ Phone:_____

Claims Address: _____ City:_____ State: _____ Zip:_____

ID Number:_____ Group Number:_____

Insured:_____ Dob:_____ Relation: _____

- For Office Use Only-

	☐ In Network	☐ Out Network
Effective Date:	___/___/_____	___/___/_____
Deductible:	$_____	$_____
Remaining:	$_____	$_____
Co-Insurance:	$_____	$_____
Co-Pay:	$_____	$_____
$ Max Allowable/yr	$_____	$_____
Max Visits/yr	___visits	___remaining

Modalities Per Visit:

w/ CMT: ____ 29200:_____

97140_____ 97810_____
Performed by LMT Under Chiro Supervision? Acupuncture

E0730_____ L3020_____
TENS Orthotics

E0855_____ L0627_____
C/S traction L/S Brace

17429 Bridge Hill Ct • Tampa, FL 33647 • (813) 983-7921 • (813) 333-2788 fax
www.NorthTampaChiropractor.com

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Chief Complaint_____

When did symptoms begin?_____ Have you had this problem before?_____

Was the Onset: ☐ Gradual ☐ Sudden Since its Onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:_____

Have you detected any possible relationship of your current complaint with any of the following?

☐Muscle Weakness ☐Bowel/Bladder problems ☐Digestion ☐Cardiac/Respiratory ☐Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription)? ☐Yes ☐No

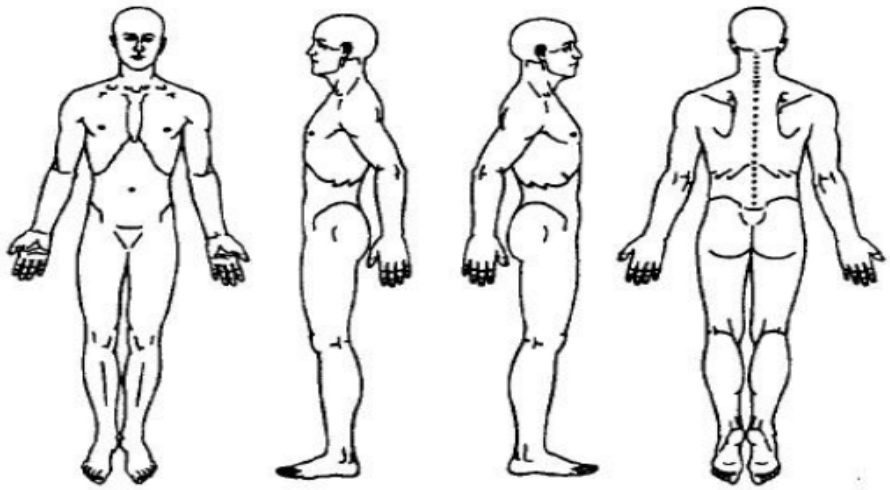
If Yes, Explain:_____ Results:_____

List Medications:_____

Currently Pregnant? ☐Yes ☐No Are you currently taking anti-coagulant or blood thinning meds? ☐Yes ☐No

PAIN CHART
Please Mark Areas of Pain using these Codes!

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
===	Throbbing
000	Stabbing/Sharp



(Front) (Left) (Right) (Back)

SEVERITY OF PAIN

List region of pain and *circle the number*, which represents the intensity of your pain.

1. Complaint:_____ No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable
2. Complaint:_____ No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable
3. Complaint:_____ No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Office Use Only:

HT_____, WT_____, BP_____, Pulse _____, OxySat _____Prev Chiro_____Benefits _____

Patient Signature_____ Date_____

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PAST HEALTH HISTORY: would you say your health is (check one): ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

1. Have you ever experienced your present problem before for which you are consulting us: ☐Yes ☐No

   If yes, When:_____. Was treatment provided? ☐Yes ☐No If yes, by whom:_____

2. Have you ever had a stroke or issues with blood clotting? ☐Yes ☐No If yes, when:_____

3. Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? ☐Yes ☐No

4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? ☐Yes ☐No

Date	Injury/Fracture/Illness/Surgery	Treatment	Results

SOCIAL HISTORY

Recreational Activities (Hobbies):_____

☐Yes ☐No Do you exercise?_____ times per week.

☐Yes ☐No Do you smoke?_____packs per day.

☐Yes ☐No Do you consume alcohol? How many drinks per week?_____

☐Yes ☐No Do you use tobacco? What/How much per day?_____

☐Yes ☐No Do you get adequate sleep? If no, Explain:_____

☐Yes ☐No Is your life stressful? If yes, Explain:_____

☐Yes ☐No Do you use recreational drugs? If yes, Explain:_____

Do you or have you ever had any problems with the following areas? (please mark **Y** or **N** in each of the following:)

1. _____Eyes
2. _____Ears, Nose, Mouth, Throat
3. _____Heart
4. _____Lungs/Breathing
5. _____Digestion/Bowels
6. _____Urinary
7. _____Muscles Pain or weakness
8. _____Nerves
9. _____Joints/Bones
10. _____Skin
11. _____Internal Organs
12. _____Blood
13. _____Allergies

Please explain any (yes) answers in space below:

_____

_____

_____

_____

_____

Family Health History (indicate which family member)

☐ Heart Disease_____ ☐ Cancer_____

☐ Diabetes_____ ☐ Arthritis_____

☐ Other _____

Patient Signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

*DO NOT SIGN UNTIL YOU HAVE REVIEWED THE LAMINATED COPIES GIVEN WITH PACKET!

_____ Patient Name (please print) Date_____

_____(if a minor) Parent, Guardian or Patients Legal Representative

_____Signature Date_____

Informed Consent

I have read or had read to the Informed Consent to treat, alternative treatments, and treatment results of a chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING I have made my decision voluntarily and freely.
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_____ Signature of Patient Date_____

_____Signature of Parent or Guardian Date_____

AUTHORIZATION AND ASSIGNMENT & OFFICE POLICIES

I acknowledge that I have read and agree to the Authorization and Assignment. I understand it is my duty to pay all debts in full to North Tampa Spine & Joint Center.
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_____ Signature of Patient Date_____

_____Signature of Parent or Guardian Date_____